Nebraska Division of Behavioral Health (DBH)

Statewide Quality Improvement Team (SQIT)

June 5, 2013 / 2:00-4:00 p.m.

DBH/Live Meeting

Meeting Minutes

I. Welcome and Attendance — *Heather Wood*

Heather welcomed everyone to the meeting and introductions were made.

Region 1:	Judie Moorehouse, Mia Knotts, Barb Vogel
Region 2:	Teresa Ward
Region 3:	Ann Tvrdik, Bev Ferguson
Region 4:	Amy Stachura, Amanda Theisen, James Alderman, Tana Godel
Region 5:	Kathleen Hanson, Patrick Kreifels
Region 6:	Stacey Brewer, Joe Dulka, Steven Baur
DHHS - Division of Behavioral Health:	Heather Wood, Cody Meyer, Jim Harvey, Lesley Shi, Robert Bussard, Sheri Dawson, Ying Wang, Mark Moore, Kathy Wilson (transcriber)
NAMI Nebraska:	Tom Adams

II. Review of Agenda & Minutes — *Heather Wood*

1. Heather reviewed the agenda. The day's focus was on:
   - Consumer Survey Update – Ying Wang
   - Consumer Education – Carol Coussons de Reyes
   - Quality Initiatives Updates – Heather Wood, Sheri Dawson, Jim Harvey, etc.
   - Continuous Quality Improvement Program Plan FY 13/14 – Heather Wood
2. Minutes of the March SQIT were dealt with by an email later from Heather.

III. Consumer Survey Update — *Ying Wang*

1. The Consumer Survey has entered the second phase of data collection and everything is going smoothly. Those initially contacted by mail are now being contacted by phone and vice versa. Copies of the brochure explaining the survey are available from the Regions or from Ying at ying.wang@nebraska.gov and on the website at http://dhhs.ne.gov/behavioral_health/Documents/Consumer-Survey-13.pdf .
2. UNMC will wrap up the Survey mid-June, the data file will be sent to DBH at the beginning of August and material presented at a TDC in October.

IV. Consumer Education — *Carol Coussons de Reyes*

1. OCA Survey on Education & Outreach (**handout attached**)
   This was one of two documents available at the Success, Hopes and Dream conference for attendees to give feedback to OCA on the type of webinars or training that is wanted in different areas of Nebraska. Feedback also was collected on the OCA Mission and Vision Statement that was first written in 2009. There will be a place on the OCA website for consumer feedback.
2. Resource Sheet (**handout attached**)
   The sheet provides contact information for a variety of resources for consumers in the Lincoln area. It could be tailored to each Region or area of Nebraska. Alternatively, it could be an appendix to the SQIT Handbook.

ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE/RESULT
Send feedback to Cynthia Harris cynthia.harris@nebraska.gov or Heather Wood heather.wood@nebraska.gov	Group	ongoing

V. **Updates on Quality Initiatives** *Sheri Dawson, Heather Wood, Jim Harvey*

1. QI Handbook (**handout attached**)
   In the beginning of SQIT, there was interest in having consumers involved. But, how to explain the activities and expectations? Diana Waggoner provided a QI manual authored by Kathi Stringer of California that set a pattern that DBH has followed. The project was later taken up by Kathleen Hanson and Dan Power. Recently, Cynthia Harris of OCA has completed a new update. Sheri went through the contents which includes a Forward by James Alderman. It is a living document, so there is a plan for updates from time to time when needed. Plan is to aggregate feedback and present again at the September 4 SQIT. Jim Harvey suggested presenting it at the September 19 Joint Advisory Meeting.

ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE/RESULT
Send feedback to Cynthia Harris cynthia.harris@nebraska.gov or Heather Wood heather.wood@nebraska.gov	Group, RQIT and providers	August 1, 2013

2. Co-Occurring
   The Co-Occurring Workgroup continues to look at what to prioritize. The Compass-EZ assessments from providers recently have been helping with the focus and direction. The Roadmap, developed by the Workgroup, is tied to the Division's Strategic Plan.
3. EBP Workgroup
   The last EBP update to the group was on December 5 when Jim reviewed the work with MedTeam, Assertive Community Treatment, Permanent Supportive Housing and Supported Employment. Co-Occurring was removed from the Workgroup's agenda. Discussions with the Regions on these ideas have been positive. Firstly, Regions want to be involved in the fidelity monitoring services purchased through their network. Secondly, SAMHSA toolkits will be used in FY14 for Permanent Supportive Housing and Supported Employment. Training on the toolkits will be carried out. Providers will be asked to do self-assessment. The third TMACT will be done in December in Hastings. As to MedTeam, Heather and Dr Shaffer had one group of this year's UNMC nursing students apply the tool to a local provider which gave us good practical experience. Their results are being studied to determine how to move forward. Block grants are to be cut 6%. So, the planned-for technical assistance may need to be reconsidered.

VI. **Continuous Quality Improvement Plan** *Heather Wood, Ying Wang*

1. Annual Goals (**handout attached**)
   It is time to look at the continuous quality annual plan: to consider goals for next FY, to discover what performance indicators will help meet those goals, and determine if there is a need for any QI initiatives to support those goals. Basically, what is the question we want to have answered and what is the priority for our system? Key components of the SQIT group are effectiveness, satisfaction, efficiency, acceptability, cost effectiveness.

Ann Tvrdik suggested initiatives around the data from Compass-EZ and from Fallot-Harris to show that the data is useful and appreciated. The goals can be basic; they do not need to be statistically complicated.
Heather reminded members of the QI Program Goals for FY13/14 (ref the handout)

2. Ying reviewed data on performance measurements.
3. There is opportunity through the performance measurements to understand how well the Division is doing.
   Kathleen Hanson believed the consumer survey will show the negative effect of system changes.
   Jim Harvey suggested that it is important to keep moving forward on trauma.
   Carol Coussons de Reyes suggested focusing on Wellness and Peer Support. She said that the People's Council is recommending the RSA, which is a recovery tool, and wondered how it compares to the TIC tool.
   Stacy Brewer cautioned not to duplicate effort when setting goals. Through the TIC findings, the group could target ways to support providers so that they can enhance their service, but by means already created in block grants and such.
   Ann Tvrdik reiterated what Stacy said. She went on to mention that they had gotten UNK to include trauma informed in the curriculum for counselors and psychologists. Perhaps the work could go on to stakeholders to provide service. Perhaps the work could be coordinated with BHECN, the courts, law enforcers and so forth.
   Kathleen Hanson and Stacy Brewer both would like to see how Nebraska compares to other states or the nation on a whole. Heather mentioned that difference in methodology may make comparison difficult.
   Heather suggested three goals: trauma and the TIC tool, recovery and the NOMs, co-occurring and the Compass-EZ.
   James Alderman added an interest in seeing separate evaluation of consumers with MH, with SA, and a combination of both.
   Carol Coussons de Reyes suggested measuring Peer-led Wellness offering. But because this will not be developed for a year, Heather suggested tabling it until the next goal review.

VII. Items for Next or a Future Agenda *Group*

- September: Housing, SQIT Handbook
- December: Consumer Survey, sharing from Regions
- Team may share agenda items with Heather as they arise.

VIII. Adjournment and Next Meeting

- Thanks to team on phone and in person.
- Meeting was adjourned at 4:00 p.m.
- Next Meeting is scheduled for Wednesday, September 4, 2013, 2:00 – 4:00 p.m. Central Time.

2013-2014 Education and Outreach of the Office of Consumer Affairs

What would you like to see from the OCA in 2013-2014?

Check or write in your answer and place in the OCA INPUT BOX.

_____ Peer Support Training

_____ Employment Skills Training

_____ Ways to Locate Community Resources and Assets

_____ Leadership Training

_____ Information on Recovery

_____ Information on Trauma

_____ Information on Consumer Involvement

_____ Information on Technology

_____ Information on Wellness Resources

Suggestions:

Resources and Contacts:

Network of Care Website of Resources for Each Region
Website: http://networkofcare.org

Office of Consumer Affairs
301 Centennial Mall South, 3rd Floor- DBH
Lincoln, NE 68509
402-471-7853/ 402-471-7859 (fax)
Email: carol.coussonsdereyes@nebraska.gov
Website:
http://dhhs.ne.gov/behavioral_health/Pages/beh_mh_mhadvo.aspx

State Ombudsman's Office
1445 K Street Lincoln, NE 68508 (402) 471-2035
Website:
http://www.nebraskalegislature.gov/divisions/ombud.php

DHHS Systems Advocate (Helpline)
PO Box 95026
Lincoln, NE 68509-5026
Toll Free: 1-800-254-4202
Website: www.dhhs.ne.gov

Nebraska Family Helpline
Toll Free: 1-888-866-8660
Website:
http://dhhs.ne.gov/behavioral_health/Pages/nebraskafamilyhelpline_index.aspx

National Suicide Prevention and Veterans Hotline
Toll Free: 1-800-273-TALK
Website:
http://www.suicidepreventionlifeline.org/

Nebraska Recovery Network
2501 South St Lincoln, NE 68502-3050 (402) 477-2372
Website: http://nebraskarecoverynetwork.org/

Nebraska Mental Health Association
1645 N St # A Lincoln, NE 68508-1824 (402) 441-4371
Website: http://www.mha-ne.org/

NAMI Nebraska
415 South 25th Ave Omaha, NE 68131
(402) 345-8101
Website: http://naminebraska.org/

Disability Rights of Nebraska
134 South 13th Street, Suite 600
Lincoln, NE 68508
Phone: 1 (402) 474-3183
Toll-Free: 1 (800) 422-6691
Website:
http://www.disabilityrightsnebraska.org/

DBSA Bellevue Moms Contact 1: Sheri Neve (402) 612-2516 Contact 2: Bob Neve (402) 614-5447/ email: bobneve@cox.net Fax: (402) 614-5447
Email: sheri.stewart@yahoo.com
Website: http://www.omahanewhope.com

DBSA Greater Omaha Contact 1: Monte Lefholtz (402) 391-2417 Contact 2: Tracy Daley (402) 690-7218 Email: dbsago@cox.net Website: www.dbsago.org

DBSA Omaha New Hope Contact 1: Randy Hughell (402) 990-8012 Contact 2: Tom Gollobit (402) 502-4673 Email: newhope.dbsa@gmail.com
Website: http://www.omahanewhope.com

Fresh Hope
3434 N. 204th Street
Elkhorn, Nebraska 68022
Ph: 402.763.9255
Email: pastorbrad@communityofgrace.net
Website: http://www.freshhope.us/
Central Nebraska Council on Alcoholism and Addictions
219 West 2nd Street, Grand Island, NE 68801
Ph: (308) 385-5520 / Fax (308) 385-5522
Website: www.cncaa.net
National Coalition for Mental Health Recovery 1101 15th Street, NW #1212 Washington, DC 20005
Toll Free : 877-246-9058
Website: http://www.ncmhr.org/
National Empowerment Center 599 Canal Street Lawrence, MA 01840 Toll-free: 800-power2u (800-769-3728) Outside US: 978-685-1494/ Fax: 978-681-6426
Website: www.power2u.org
National Mental Health Consumer Self Help Clearinghouse
1211 Chestnut Street, Suite 1207 Philadelphia, PA 19107 Toll Free: (800) 553-4539/ (215) 751-1810 Fax: (215) 636-6312 E-mail: info@mhselfhelp.org
Website: http://www.mhselfhelp.org/
Faces & Voices of Recovery 1010 Vermont Ave. #708 Washington, DC 20005 (202) 737-0690/ Fax (202) 737-0695
Website: http://www.facesandvoicesofrecovery.org/
The Carter Center- Mental Health Program One Copenhill 453 Freedom Parkway Atlanta, GA 30307 (404) 420-5100/ Toll Free (800) 550-3560
Website: http://www.cartercenter.org/index.html
Depression and Bipolar Support Alliance 730 N. Franklin Street, Suite 501 Chicago, Illinois 60654-7225 Toll-free: (800) 826-3632 / Fax: (312) 642-7243
Website: http://www.dbsalliance.org
STAR Center 3803 N. Fairfax Dr., Suite 100 Arlington, VA 22203 Toll-Free: (866) 537-STAR (7827) Fax: (703) 600-1112
Website: http://www.consumerstar.org/index.html
Mental Health America-Consumer Supporter
Centers for Technical Assistance 2000 N. Beauregard Street, 6th Floor Alexandria, VA 22311 Toll Free: (866) 439-9465 / Fax. (703) 684-5968 E-mail: ConsumerTA@nmha.org
Website: http://ncstac.org/index.php
Matt Talbot Food Kitchen
2121 N. 27th Street,
Lincoln, NE
(402)-477-4116
Website: http://www.mtkserves.org/
Substance Abuse Mental Health Services Administration (SAMHSA), CSAT, CMHS, CSAP, OCA
P.O. Box 2345 Rockville, MD 20847-2345
Email: SAMHSAInfo@samhsa.hhs.gov Toll Free: 1-877-SAMHSA-7 (1-877-726-4727)
TTY: 1-800-487-4889 Fax: 240-221-4292
Website: http://store.samhsa.gov/
The Kim Foundation
C&A Plaza 13609 California Street Omaha, NE 68154 (402) 891.6911 Website: www.thekimfoundation.org
Boys Town
14100 Crawford Street.
Boys Town, NE 68010
Toll Free: 1-800-448-3000
Website: www.boystown.org

Department of Health & Human Services

DHHS

NEBRASKA

SQIT HANDBOOK

June 2013

Statewide Quality Improvement Team

Division of Behavioral Health

Acknowledgements:

Thank you to Diana Waggoner, of the Kim Foundation, for sharing the work of Kathi Stringer with the Division of Behavioral Health. Kathi developed a quality improvement committee (QIC) manual for the California Network of Mental Health Clients. The manual was developed by consumers for consumers.

A small committee of the Statewide Quality Improvement Team (SQIT) met to review Kathi's QIC manual and discussed how it might be adapted for our SQIT. Thank you to Kathleen Hansen for her vision and work to move the development of the manual forward.

Thank you to those who offered recommendations for improving the SQIT Handbook.

Carol Coussons de Reyes
Cynthia Harris
James Alderman
Joseph Dulka
Cody Meyer
Nancy Heller
Scot Adams
Sheri Dawson
Heather Wood

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Division of Behavioral Health
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Ph: 402-471-3121
http://dhhs.ne.gov/behavioral_health/

Foreword
Believing in Yourself
An Unedited Perspective
By: James Alderman

The biggest problem with living with a Mental Illness, is people that think they don't.

My name is James I am a member of the Statewide Quality Improvement Team. It is a group of individuals and family members and professionals that look at new and old practices and hope to improve the kind of services for people that have a Mental Illness or a Substance abuse problem.

I found out about SQIT through the Office of Consumer Affairs. I joined the SQIT team because the more that is known about Mental Illness. The more that Consumers involvement has become the path that the state has taken. I am very excited to be a part of this process of learning more about people with Mental Illnesses and finding out that instead of being passive an just watching your life be dictated by an illness that has knows no boundaries and has no respect for the victim.

I was diagnosed with Schizophrenia when I was 22 years old. I will be 60 this year. When I had my first episode. I was afraid, I feared for my life and I thought that I would be put in a Mental Institution for the rest of my life. My family has a history of Mental Illness on both parents sides.

The reason I am writing his is because after many, many years of stopping taking my medicine because I thought that I was cured and spending countless hospitalizations. I finally accepted my mental illness as a blessing and an answer and went to the hospital to stay until I got help, but I didn't believe in myself and I turned inside myself and I thought everybody else had forgotten me and I had no friends and I was pretty much wondering why I was being locked up because I was Ill. I attended day programs and after several years of soul searching. I believed enough in myself that I could be helped. By believing in myself that I could help myself and make a difference in my life and also the lives that I can give myself a chance to succeed and accept myself. Just because I have a Mental Illness doesn't mean I have to reject my own beliefs. I'm not wrong just because I have a Mental Illness and by sharing my experiences and maybe someday people will find out the truth about People with Mental Illnesses like myself.

The more people that can find courage and strength and want to do something to improve their lives and come out of their comfort zones and instead of watching their passing them in front of their eyes. Then that is why I am on the SQIT and writing this chapter on Belief. I believe was created by the same being that created I believe in and that this is what I was created to do and that is help someone else come to believe that they have a right to.

I believe that I can contribute, and change the way that can make a difference in how people believe about myself and others that are perceived as being Mentally Ill. I want you to have a chance to change how people judge you also and let them know that the more you participate in your community and make yourself an example of what is true about you and believe in you.

I am writing this because this isn't just about me, but you why I am writing this because I believe in you and I want you to believe in you too. I want all of the voices to be heard.

Table of Contents

Chapter 1

Introduction: What is the Statewide Quality Improvement Team

The Statewide Quality Improvement Team (SQIT) is a workgroup of the Nebraska Department of Health and Human Services – Division of Behavioral Health. The primary responsibility of SQIT is to identify and prioritize ways that the behavioral health care system can be improved at regional and statewide levels.

The Division of Behavioral Health (DBH) is committed to the residents of Nebraska and to providing them with quality community services devoted to treating mental health and substance use disorders. Collecting and reviewing consumer information allows us to demonstrate outcomes as well as secure funding for effective programs. To that end, DBH collects data that is necessary to ensure:

- Access to and continuation of services;
- Services meet state and federal criteria; and
- DBH is funding services that have a positive impact and improve the quality of life for behavioral health consumers.

The SQIT is comprised of representatives from throughout the state and include:

- Consumers/consumer specialists and family members
- Regional Quality Improvement Team members
- Division of Behavioral Health staff, and
- Network Providers who pay for behavioral health care services.

The recommendations of the SQIT are used by the Division of Behavioral Health to develop a Continuous Quality Improvement Program Plan for behavioral health reform in the State of Nebraska.

The primary responsibilities of the SQIT include:

- Ensuring effective communication between the team and the agencies, organizations and individuals that it represents.
- Analyzing surveys and studies that are designed to assess consumer/family satisfaction of existing behavioral health care services.
- Monitoring the quality of programs that are designed to improve behavioral health care services at regional, local and community-based levels.
- Offering recommendations on QI policies, procedures and service definitions.
- Evaluating the effectiveness of the Continuous Quality Improvement Program each year.
- Revising the Annual Continuous Quality Improvement Program Plan.
- Ensuring that adequate training exists to support the Continuous Quality Improvement Program Plan.

Chapter 2

Being a Systems Advocate

What is advocacy? Advocacy is defined as the act of pleading for, supporting, or recommending; active espousal. There are two types of advocacy; individual and systems. Individual advocacy changes things for one person and systems advocacy changes things for a group of people (Mead, 2010). Although there is a difference between the two, systems advocacy would not exist without the collaborative efforts of individual advocates coming together to create a larger systems coalition. Successful advocacy offers many voices, many perspectives, clear, conscience, and consistent messages, professionalism, education, and solutions (Mead, 2010).

Local, state, and federal officials need to know constituent needs. As an advocate, you have essential knowledge and expertise about issues that leaders may not know. They need to hear you! Systems advocates use information from other's comments and personal experiences, their own personal experiences, newspapers, organizational newsletters, and meetings minutes. Systems advocates participate on committees, commissions, tasks forces, and boards. They demand a seat at the table on issues that concern them. Systems advocates make their expertise known and become a valuable resource in advocating for the group of people (Mead, 2010).

Each individual advocates in ways that are comfortable for him or her, and each individual advocate brings valuable expertise and knowledge to the table. The collective efforts of individual advocates to form the larger systems advocate is a very powerful tool in creating change. By identifying the obstacles, developing strategies to overcome them, and then implementing these plans, systems advocacy is creating a voice for every consumer. Everyone can make a difference (Mead, 2010).

When you are a systems advocate it is important to identify issues (Mead, 2010).

- Types of consumer issues.
- Changes in services or practices.
- Changes in policy.
- Changes in budget allocations.
- Proposed changes.
- Incomplete or confusing information.
- Unmet needs.
- Unresponsiveness to needs.
- Resistance or hostility.

Some strategies for being a systems advocate (Mead, 2010):

- Believe in possibilities.
- Be clear about your values, measure actions, strategies and outcomes against them.
- Disagree on issues, NOT with people.
- Advocate for the best scenario, never start with a compromise.
- Communicate, communicate, and don't forget communicate!
- Use a variety of approaches, from a variety of groups.
- Reach out to groups with a similar interest and form situational coalitions and for a specific change (community organizing).
- Don't allow yourself to be pitted against sister groups.
- Vote!
- Impact the legislative process.

Chapter 3

How Can I Participate in the Statewide Quality Improvement Team?

Participation in the SQIT is an essential component for achieving the overall mission of the Continuous Quality Improvement Program for mental health reform in the State of Nebraska.

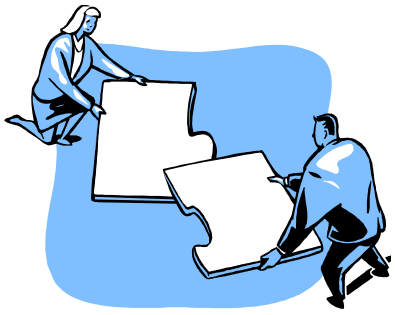
Mission: The Division of Behavioral Health leads Nebraska in the improvement of systems of care that promote and facilitate resilience and recovery.

Commitment: DBH is committed to creating a culture that fosters quality improvement and sets clear direction through an annual plan.

Purpose*:* The DBH Continuous Quality Improvement (CQI) Program establishes accountability for continually improving DBH as an organization and the services provided to consumers and families in the state of Nebraska.

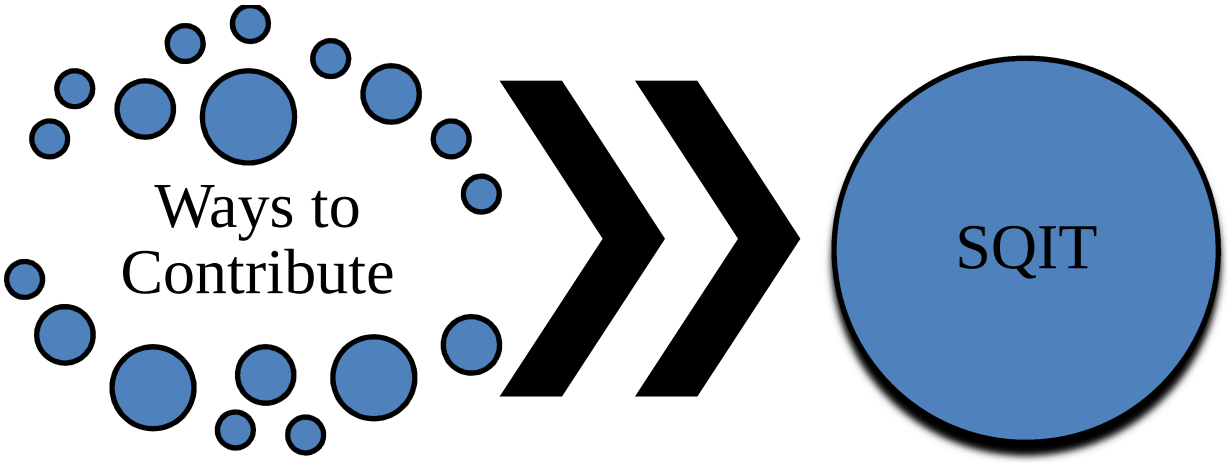
As a member, you will contribute to the QI program's mission, commitment and purpose on which the SQIT has been established. You will help ensure services are appropriate to each consumer's needs and accessible when needed, that consumers and families participate in all process of the CQI program, and that their views and perspectives are valued. You will also ensure that the services provided incorporate best practice, evidence based practice, and effective practices, and that those services are of high quality and provided in a cost-effective manner.

> Data elements and collection methods, including those for prevention and treatment data as well as for measuring consumer satisfaction, receive ongoing review. At times modifications for improved quality are identified through performance monitoring with the help of committees such as the Statewide Quality Improvement Team (SQIT), Magellan Quality Improvement Team (MQIT), and Regional Quality Improvement Teams (RQIT). The Division has found that through collaboration with key stakeholders our improvement efforts and training resources have made a positive impact on the accuracy and reliability of data collected. This level of quality in our data is essential to the work we do as it helps us measure and assess the impact of our programs. We are committed to continuous quality improvement because our data and reporting work represents far more than averages or trends that can be visually displayed; they represent the prevention and treatment work which has been completed and the work which remains in order to sustain a system of recovery offering a life better lived for our behavioral health consumers in Nebraska.



Your involvement is important for accurately assessing the quality of behavioral health care services and how they can be improved. In addition to the primary responsibilities of the SQIT listed in the introduction of this handbook, the following includes, but is not limited to, ways in which consumers can contribute to the SQIT:

- Reviewing the results of consumer and family based surveys and/or studies, which are designed to assess consumer/family satisfaction of existing behavioral health care services, to provide insight on how the results pertain to individuals that require behavioral health care.
- Advising DBH and SQIT on the development of the CQI Plan, activities, measures, and indicators.
- Providing input into the creation of quality improvement initiatives.
- Assisting in the development of education and communication processes.
- Serving as Consultants to DBH representing various viewpoints and concerns.
- Reviewing CQI reports and making recommendations.
- Developing, implementing and monitoring of the community QI Program.
- Ensuring data collection and information are used to manage and improve service delivery at the local level.
- Providing ongoing information about performance and improvements to persons served.
- Reviewing minutes and reports.
- Identifying agenda/ meeting topics.



There are Various levels of Participation

All Levels contribute to the overall mission and vision

Chapter 4

SQIT Meetings: What to Expect

What to review prior to meeting:

- Consumer Handbook; including current QI program plan goals and initiatives.
- Nebraska Division of Behavioral Health Strategic Plan.
- The last three months of SQIT meeting minutes; ask for past handouts such as agendas and power points.
- Current agenda, power points, handouts, etc., if provided.

What to bring:

- A copy of current agenda, power points, handouts, etc., if provided.
- A copy of the Consumer Handbook.
- A note pad and writing utensils.
- A highlighter to emphasize important topics and create reminders.
- Optional: A copy of the Nebraska Division of Behavioral Health Strategic Plan.

How to locate information:

- Past SQIT meeting minutes and the Consumer Handbook can be located online at http://dhhs.ne.gov/behavioral_health/Pages/beh_sqit_sqit.aspx
- If online access is not available, please contact Heather Wood for information. See below for her contact information.

Have questions during the SQIT meeting? Or want to add an item on the agenda?

If during an SQIT meeting there is information that is unclear, it is ok to ask questions. Your participation and feedback is encouraged. Chances are that you are not the only person who has the same questions. Asking questions can also lead to discovering more ways to enhance quality improvement. In addition, questions generate useful information. If you are interested in getting an item on a future agenda or have further questions please contact:

Heather Wood
Quality Improvement and Data Performance Administrator
Division of Behavioral Health
PO Box 95026
Lincoln NE 68509-5026
Phone: (402) 471-1423
FAX: (402) 471-7859

Chapter 5

Division of Behavioral Health
Continuous Quality Improvement Program Plan Basics

The Division of Behavioral Health CQI program will ensure:

- Services are appropriate to each consumer's needs and accessible when needed;
- Consumers and families participate in all process of the CQI program and their views and perspectives are valued;
- The services provided incorporate best practice, evidence based practice, and effective practices;
- Services are of high quality and provided in a cost-effective manner.

Definition:

CQI is an ongoing process of using data to plan, identifying opportunities for improvement, implementing changes, studying and analyzing results and celebrating improvements.
The CQI Program is based on the following assumptions:

- Working together creates a system of coordinated services to better meet the needs of consumers and families;
- Stakeholders want to improve consumer and family outcomes;
- Stakeholders participate in monitoring activities, data reporting and information sharing

The DBH's approach to quality improvement is based on the following core principles:

- *Customers Focused*. Understanding and respecting needs and requirements of all customers and striving to exceed expectations.
- *Strength Based*. Effective growth and change build on the consumer/family and system's strengths.
- *Recovery Oriented*. Services are characterized by a commitment to promoting and preserving wellness and choice. This approach promotes maximum flexibility to meet individually defined goals in a consumer's recovery journey.
- *Representative Participation and Active Involvement*. Effective programs involve a diverse representation of stakeholders. The stakeholders are provided the resources, education and opportunity to make improvements required and influence decision making.
- *Data Informed Practice.* Successful QI processes create feedback loops, using data to inform practice and measure results. There is a commitment to seek IT structures, staff, skills and other resources in the provision of data.
- *Use of Statistical Tools.* For continuous improvement of services, tools and methods are needed that foster knowledge and understanding. CQI organizations use a defined set of analytic tools

such as run charts, cause and effect diagrams, flowcharts, Pareto charts, histograms, and control charts to turn data into information.

- *Continuous Quality Improvement Activities*. Quality improvement activities emerge from a systematic and organized framework for improvement. This framework, adopted by the Division of Behavioral Health, is understood, accepted and utilized throughout the service delivery system, as a result of continuous education and involvement of stakeholders at all levels in performance improvement.

Leadership and Stakeholders:
Leaders, through a planned and shared communication approach, ensure all stakeholders have knowledge of and participation in ongoing QI activities as a means of continually improving performance. Planned communication methods include posting QI information on the DHHS-DBH public website.

The CQI process must be stakeholder driven. Stakeholders include Consumers and Families, DBH Administration and Staff, Consultants, Regional Staff, Service Providers, Advocacy Groups and Office of Consumer Affairs Participants, Managed Care Staff, DHHS Partners, etc. Working Relationships are pictured and described below.

Division of Behavioral Health Administration – The DBH Director and Community Services Section Administrator establish and communicate priorities for the annual plan and review feedback from stakeholders in the reporting structure.

Behavioral Health Advisory Committees (MH, SA) **-** Contributes to the development and implementation of the Annual CQI Plan and activities. The committees meet quarterly.

Regional Administrator and Network Management Team Meetings **-** Ensure that quality improvement processes are operationalized and prioritized at the community team level. Regional Administrators meet regularly with DBH Administration and the NMT is held quarterly.

Statewide Quality Improvement Team (SQIT) **-** primarily responsible for the identification and prioritization of opportunities for regional/community improvement, quality initiatives and development of the annual plan. 50% of voting membership should have a disclosed lived behavioral health experiences

Regional Quality Improvement Teams (RQIT) - Contributes to the development and implementation of local QI activities as it relates to local needs and the DBH CQI Program Plan. Meetings are held on a regular basis.

Magellan Quality Improvement Team (MQIT) **-** Primary responsibilities include improvement of data quality utilized in QI processes and activities.

* Please see Appendix D for the current year's CQI program plan's goals and initiatives.

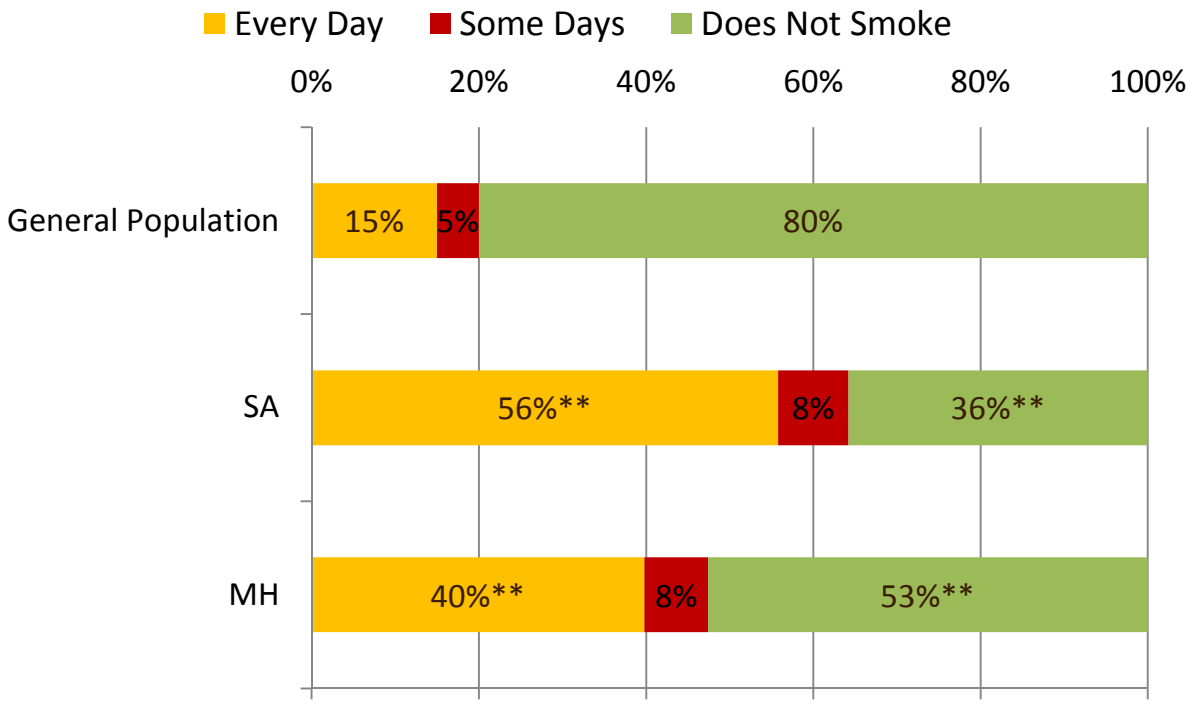
Chapter 6

What are the Statewide Quality Improvement Team Measures?

The purpose of these definitions is to provide the SQIT team member with a guide to understanding how data is used throughout the quality improvement process. The terms that are defined below can assist in interpreting and evaluating statistical data. These terms are important because they define elements involved in continuing the implementation of performance measurement monitoring and reporting processes. Continuous review of data variables is required to report on performance outcomes and monitor data for integrity and accuracy.

Baseline Measures

The purpose of a baseline measure is to provide an initial aggregate of data, or starting point. Baselines are important because changes in data are measured against the baseline. For example if the number 0 was a baseline and there was an increase of 15. The difference between 15 and 0 would be used to assess the overall change. The general population is often used as a baseline measure when in comparison with other population groups. See below for example.



Fidelity Monitoring

There are models or services of behavioral healthcare that are funded by the federal and state government. The federal and state government wants to know that they are purchasing what they want to purchase. Having high fidelity in a model or service means that the service is very close to what was intended. Having low fidelity means that a model or service is very different than what was intended.

People want to know if the models or services are the same, because they spend a lot of money researching different models or services to know whether or not they work. When people are planning at the federal or state level they like to have research behind services so they have confidence that they are buying services that are going to make a difference.

An example of such a service is called an assertive community treatment team (ACT). ACT is supposed to have a team whose membership includes a peer specialist that lives with a behavioral health condition; it is a key component. If an ACT team didn't hire a peer specialist that lives with a behavioral health condition, it would not have *high fidelity*.

Another way fidelity is used is in data teams. Teams of people get together to measure different services or models. The way that the team is trained is supposed to be all the same, so that all the people are measuring the service or model the same way. This is called training in *fidelity monitoring*. *Fidelity* is basically a decision making process. You want to know that the same rules are applied to all circumstances, across settings and across time.

NOMS

Substance Abuse and Mental Health Services Administration's (SAMHSA, 2013) National Outcome Measures (NOMs) is a reporting system that was developed to create an accurate and current national picture of substance abuse and mental health services. The NOMs serve as performance targets for state- and Federally-funded programs for substance abuse prevention and mental health promotion, early intervention, and treatment services.

The NOMs exemplify meaningful, real life outcomes for people who are striving to achieve and sustain recovery, build resilience, work, learn, live, and participate fully within their communities. Within NOMs there are 11 priority areas, one of which addresses co-occurring disorders (COD).

Each area is subdivided into three areas (SAMHSA, 2013):

- Mental health services
- Substance abuse treatment
- Substance abuse prevention

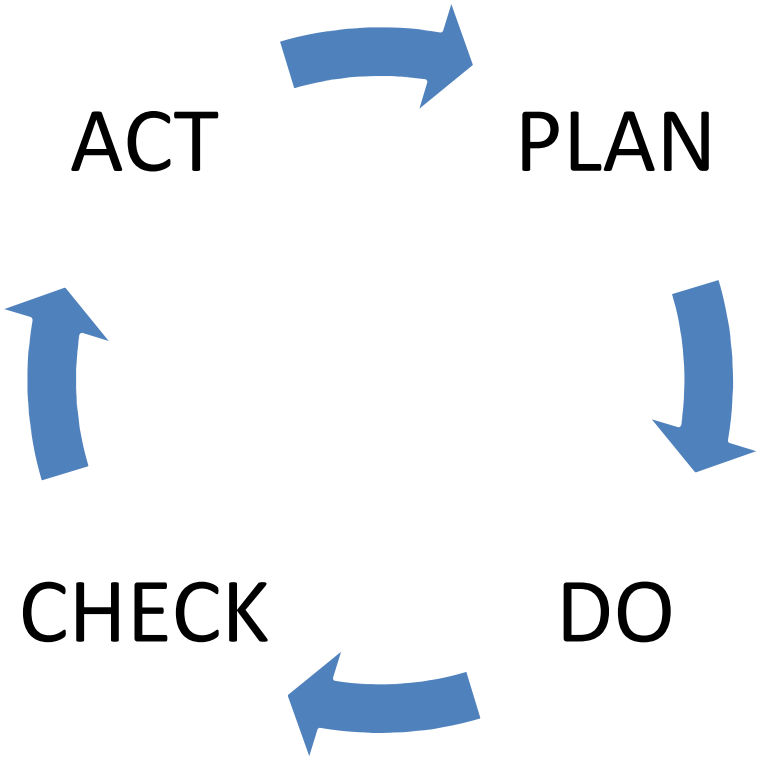
Each area is further subdivided into ten domains:

- Reduced Morbidity
- Employment/Education
- Crime and Criminal Justice
- Stability in Housing
- Social Connectedness
- Access/Capacity

- Retention
- Perception of Care (or services)
- Cost Effectiveness
- Use of Evidence Based Practices

Performance Measure Monitoring
Performance measurement is about reporting information about the performance of an individual, group, or organization. When we monitor performance measurements, we are looking at outcomes of individuals, groups, or organizations and areas such as: utilization of care, health plan stability, availability and access to care, and other various structural and operational aspects of health care services. People practice performance measurement to control, celebrate, budget, motivate, evaluate, or improve themselves or others.

Continuous Quality Improvement (CQI)
CQI is an ongoing process of using data to plan, identifying opportunities for improvement, implementing changes, studying and analyzing results and celebrating improvements. We use the Plan-Do-Check-Act (PDCA) model.

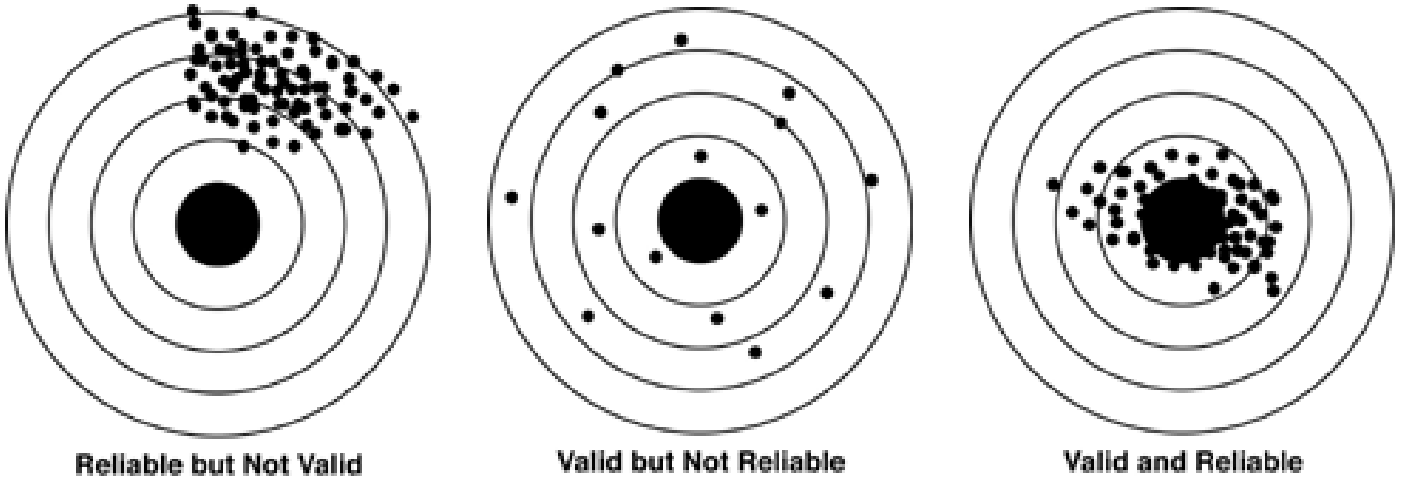


Reliability / Validity

Reliability is the consistency of a measurement tool. *High Reliability* means the same results appear again and again when a measure is applied to the same conditions. An example of something with high reliability is the Certified Peer Support and Wellness Specialist exam, most people that take the exam after going through training pass. This result happens again and again; therefore the exam has high reliability.

Validity is a process of measuring what you intend to measure. Researchers need to make sure that their findings and analyses are accurate. Validating data means checking for accuracy and credibility. There are procedures that are used to increase validity such as (Clark & Creswell, 2010):

- Random assignment to groups so that differences are spread across all groups.
- Measuring other variables that need to be controlled. This can be done by giving a pretest and a post-test to assess individual attitudes that may be related to how individuals respond.
- Random selection of individuals to participate in the study.
- Encouraging many people to respond. With a larger sample size the results can be generalized. Generalization is the process of applying the findings to the general population.



Survey

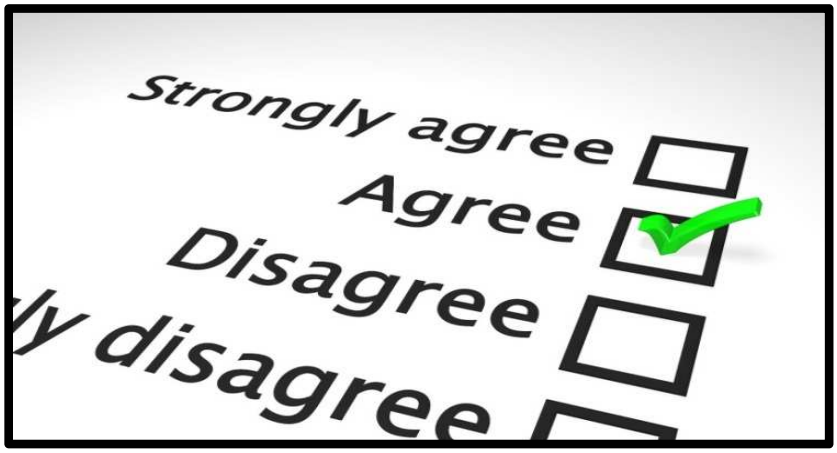
A *survey* is a data tool or way of collecting specific information. A survey may ask factual questions about individuals or it may ask opinions of the survey takers. One method of taking a *survey* is a structured interview where an interviewer reads and records the answers provided to questions. Another method is a questionnaire where the individual works by themselves to answer the questions being asked on a paper or online questionnaire. *Surveys* can take place on the phone, through the mail, on the computer, or at a face to face interview.

Surveys are a quick, easy, and inexpensive way of getting information. They can have bias though reflected by how many people respond to the types of question being asked, or due to the limitation of too few choices on the survey versus other feelings a person may have. There is a process called standardization of *surveys*, where they are tested for reliability and validity. When a survey is standardized the information collected is done in a similar way for all participants (Clark & Creswell, 2010).

The annual DBH Consumer Survey runs from February to June, and a new group of people is asked to participate each year. Each participant is selected completely at random from the population of those we serve. This survey has been conducted annually since 2005 and helps the Division evaluate the quality and impact of services that are provided. Survey results can be found http://dhhs.ne.gov/behavioral_health/

The Consumer Survey monitors seven key quality improvement areas of behavioral health services:

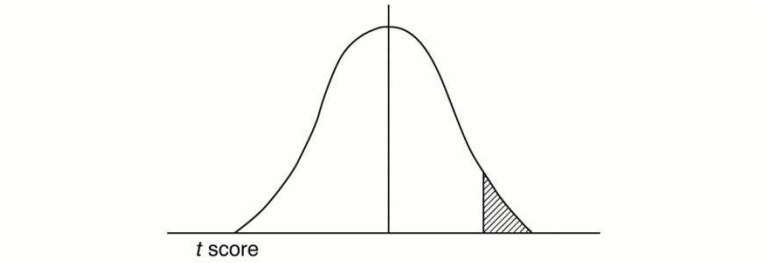
- Accessibility of the services
- Quality and appropriateness
- Recovery outcomes
- Participation in treatment planning
- General satisfaction with the services
- Life functioning
- Social connectedness



(Some Body Healme.com, 2013).

T-Tables

T-tables display T-values, which test for a difference between two groups. It displays continuous probability distributions that arise when estimating the mean of a normally distributed population in circumstances where the population standard deviation is unknown. Standard deviation is a way to measure how dispersed the data points are in regards to the mean (average) of the data (Clark & Creswell, 2010). It plays a role in evaluating the statistical significance of the difference between two sample means, the construction of confidence intervals for the difference amongst two population means, and in linear regression analysis (Clark & Creswell, 2010).



df \ p	0.1	0.05	0.025	0.01	0.005
1	3.078	6.314	12.706	31.821	63.657
2	1.886	2.920	4.303	6.965	9.925
3	1.683	2.353	3.182	4.541	5.841
4	1.533	2.132	2.776	3.747	4.604
5	1.476	2.015	2.571	3.365	4.032
10	1.372	1.812	2.228	2.764	3.169
11	1.363	1.796	2.201	2.718	3.106
12	1.356	1.782	2.160	2.650	3.055
13	1.350	1.771	2.160	2.650	3.012
14	1.345	1.761	2.145	2.624	2.977
15	1.341	1.753	2.131	2.602	2.947
24	1.318	1.711	2.064	2.492	2.797

(Emergency Medicine Journal, 2001).

URS Tables

URS (Uniform Reporting System) tables are tables that provide statistical data on mental health national outcome measures (NOMS). The tables are provided by SAMHSA's Center for Mental Health Services (CMHS). CMHS provides assistance and technical support to decision makers at all levels of government on the design, structure, content, and use of mental health information systems. The ultimate goal is to improve the quality of mental health programs and services delivery. CMHS operates the only program in the Nation that focuses on the development of data standards that provide the basis for uniform, comparable, high-quality statistics on mental health services (SAMHSA, 2013).

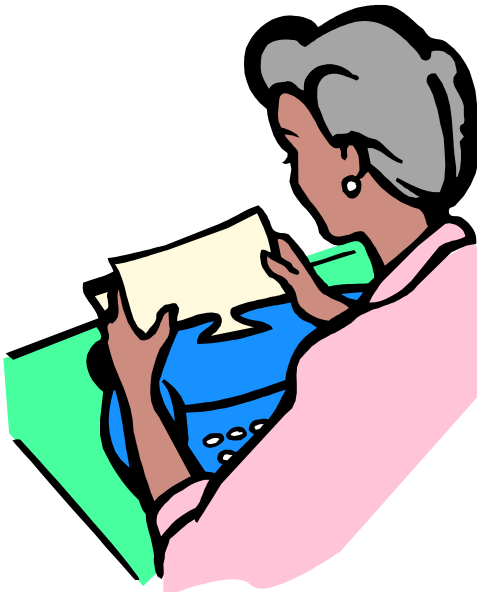
Chapter 7
From the Regions' Perspective

Region 3

SQIT has helped to bring all parties of the behavioral health services delivery system to a common place and using a common language. By incorporating all stakeholders in the composition of the group, every perspective from consumer and family through clinician, agency, Region and Division of Behavioral Health are embodied in the decision-making on outcome measurements, the use of data and the reporting of quality improvement results. The most important voice in the process is the consumer and family because they remind everyone what is most important, providing quality services to Nebraska behavioral health consumers to assist them in recovery.

Region 5

An effective behavioral health system requires a commitment to, and participation in, continuous quality improvement activities. The Statewide Quality Improvement Team is an opportunity for stakeholders from across Nebraska to work together towards ensuring a statewide system of care that promotes wellness and recovery SQIT stakeholders includes consumers, families, state and regional representatives who identify and prioritize opportunities for quality improvement. The Division of Behavioral Health and Regional Behavioral Health Authorities value the voice of consumers and families and encourage their participation in SQIT. The value of different but equally important perspectives strengthens the overall quality of the behavioral health service system at the state and local levels.



Appendix A:
Frequently Used Acronyms

ACT	Assertive Community Treatment
ATOD	Alcohol, Tobacco, and Other Drug
BG	Block Grant
BH	Behavioral Health
BHSIS	Behavioral Health Services Information System
BRFSS	Behavioral Risk Factor Surveillance System
CADAC	Certified Alcohol & Drug Abuse Counselor
CAFAS	Child & Adolescent Functional Assessment Scale
CAP	Client/Consumer Assistance Program
CAPTs	Centers for the Application of Prevention Technologies
CBHSQ	Center for Behavioral Health Statistics and Quality
CBPR	Community-Based Participatory Research
CFR	Code for Federal Regulations
CFS	Child and Family Services
CHC	Community Health Center
CMHS	Center for Mental Health Services
COD	Co-Occurring Disorder
CPSWS	Certified Peer Support and Wellness Specialist
CS	Community Support
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
CSCI	Consumer Survey Communication Improvement
CTA	Community Treatment Aid
CQI	Continuous Quality Improvement
DBH	Division of Behavioral Health
DHHS	Department of Health and Human Services
DIG	Data Infrastructure Grant
EBP	Evidence Based Practice
EBT	Evidence Based Treatment
F/PCP	Family/Person Centered Practice
FY	Fiscal Year
GAP	Gamblers Assistance Program
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability & Accountability Act
HRA	Housing Related Assistance
IOP	Intensive Outpatient
IPP	Individual Program Plan
IRP	Individual Rehabilitation Planning
IRT	Intermediate Residential Treatment
IPS	Individual Placement and Support

ITP	Individual Treatment Plan
LADAC	Licensed Alcohol & Drug Abuse Counselor
LCRT	Local Crisis Response Team
LGBT	Lesbian, Gay, Bisexual and Transgendered
LGBTQ	Lesbian, Gay, Bisexual, Transgendered and Questioning
LMHP	Licensed Mental Health Practioner
LRC	Lincoln Regional Center
MBHO	Managed Behavioral Healthcare Organization
MCO	Managed Care Organization
MedTEAM	Medication Treatment, Evaluation, and Management
MH	Mental Health
MHA	Mental Health Association
MHSIP	Mental Health Statistics Improvement Program
MQIT	Magellan Quality Improvement Team
NMT	Network Management Team
NOMs	National Outcome Measures
NPIRS	National Patient Information Reporting System
NREPP	National Registry of Evidence-based Program and Practice
NRPFSS	Nebraska Risk and Protective Factor Student Survey
NRRI	Not Responsible by Reason of Insanity
NSDUH	National Survey on Drug Use and Health
OCA	Office of Consumer Affairs
PDCA	Plan-Do-Check-Act
PG	Problem Gambling
PPC	Privacy Protection Center
PPP	Professional Partner Program
PS	Peer Support
QI	Quality Improvement
RBHA	Regional Behavioral Health Authority
RQIT	Regional Quality Improvement Team
RGB	Regional Governing Board
RFP	Request for Proposal
SA	Substance Abuse
SAMHSA	Substance Abuse & Mental Health Services Administration
SE	Supported Employment
SOMMS	State Outcomes Measurement and Management Systems
SQIT	Statewide Quality Improvement Team
TAD	Turn Around Document
TFN	Tobacco Free Nebraska
TIN	Trauma Informed Nebraska
TMACT	Tool for Measuring Assertive Community Treatment
UNMC	University of Nebraska Medical Center
URS	Uniform Reporting System
WRAP	Wellness Recovery Action Plan

Appendix B:

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Appendix C:

Proposed 206 Rules and Regulations Draft

3-003 QUALITY IMPROVEMENT: The Division will develop, implement, and maintain quality improvement functions designed to continually assess and improve the outcomes of the community behavioral health programs funded in whole or in part by the Division.

3-003.01 The Division will develop an annual quality improvement plan.

3-003.01A Outcome Measures: RBHA's must collect data on outcome measures. Outcome data reporting requirements may be included in contracts or in a written document and will outline data to be collected and specific outcome measures related to the Emergency Systems, Youth Systems, Consumer and Family System, and the Network Management System, as well as any federal block grant outcome measurement reporting requirements.

3-003.02 The Division will monitor the submissions and hold contractors accountable to correct any undesired trends or variations from the acceptable range. Failure to achieve desired results over a period of time may result in technical assistance or corrective action, if necessary.

Appendix D:

Current SQIT Plan
DHHS-Division of Behavioral Health
Continuous Quality Improvement Program Plan
FY12/13

Section 1
Introduction

Vision:

The vision of the Division of Behavioral Health (DBH) and its Quality Improvement Program is to promote wellness, recovery, resilience and self-determination in a coordinated, accessible consumer and family-delivery system.

Mission:

The Division of Behavioral Health leads Nebraska in the improvement of systems of care that promote and facilitate resilience and recovery.

Commitment:

DBH is committed to creating a culture that fosters quality improvement and sets clear direction through an annual plan.

Purpose:

The DBH Continuous Quality Improvement (CQI) Program establishes accountability for continually improving DBH as an organization and the service provided to consumers and families in the state of Nebraska.

The Division of Behavioral Health CQI program will ensure:

- Services are appropriate to each consumer's needs and accessible when needed;
- Consumers and families participate in all process of the CQI program and their views and perspectives are valued;
- The services provided incorporate best practice, evidence based practice, and effective practices;
- Services are of high quality and provided in a cost-effective manner.

Definition:

CQI is an ongoing process of using data to plan, identifying opportunities for improvement, implementing changes, studying and analyzing results and celebrating improvements.

The CQI Program is based on the following assumptions:

- Working together creates a system of coordinated services to better meet the needs of consumers and families;
- Stakeholders want to improve consumer and family outcomes;
- Stakeholders participate in monitoring activities, data reporting and information sharing.

The DBH's approach to quality improvement is based on the following core principles:

- ***Customers Focused***. Understanding and respecting needs and requirements of all customers and striving to exceed expectations.
- ***Strength Based.*** Effective growth and change build on the consumer/family and system's strengths.
- ***Recovery Oriented.*** Services are characterized by a commitment to promoting and preserving wellness and choice. This approach promotes maximum flexibility to meet individually defined goals in a consumer's recovery journey.
- ***Representative Participation and Active Involvement***. Effective programs involve a diverse representation of stakeholders. The stakeholders are provided the resources, education and opportunity to make improvements required and influence decision making.
- ***Data Informed Practice***. Successful QI processes create feedback loops, using data to inform practice and measure results. There is a commitment to seek IT structures, staff, skills and other resources in the provision of data.
- ***Use of Statistical Tools***. For continuous improvement of services, tools and methods are needed that foster knowledge and understanding. CQI organizations use a defined set of analytic tools such as run charts, cause and effect diagrams, flowcharts, Pareto charts, histograms, and control charts to turn data into information.
- ***Continuous Quality Improvement Activities***. Quality improvement activities emerge from a systematic and organized framework for improvement. This framework, adopted by the Division of Behavioral Health, is understood, accepted and utilized throughout the service delivery system, as a result of continuous education and involvement of stakeholders at all levels in performance improvement.

Plan-Do-Check-Act (PDCA) Model

The recommended model for problem solving and improvement is PDCA. It should be utilized:

- When starting a new improvement project;
- When developing a new or improved design of a process or service;
- When planning data collection and analysis in order to verify and prioritize; and
- When implementing any change.

Plan – Plan for a specific improvement activity

- Recognize opportunity for improvement
- What are the issues?
- Plan a change – who, what, when
- Determine how change will be measured

Do - Do carry out the plan for improvement

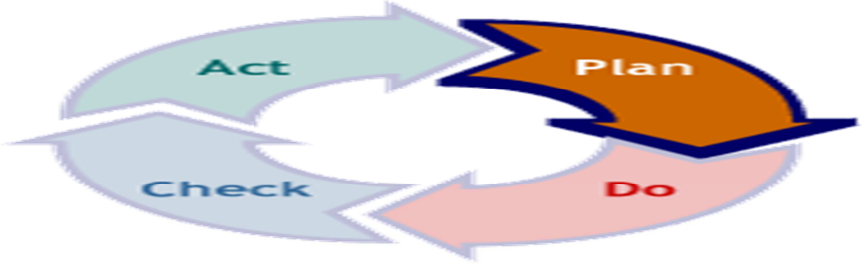
- Gain approval and support of the selected improvement solution.
- Implement the improvement solution.
- May use a trial or pilot implementation
- Document observations and data

Check - Check the data again

- Data is analyzed to compare the results of the new process with those of the previous one
- Check for improvement and results
- What was learned?

Act – Action for full implementation or reject and try again

- Take action based on what was learned
- Adopt the solution formally as needed, develop policy, etc.
- If there is no improvement refine/revise the solution
- If successful, take action to ensure ongoing improvement

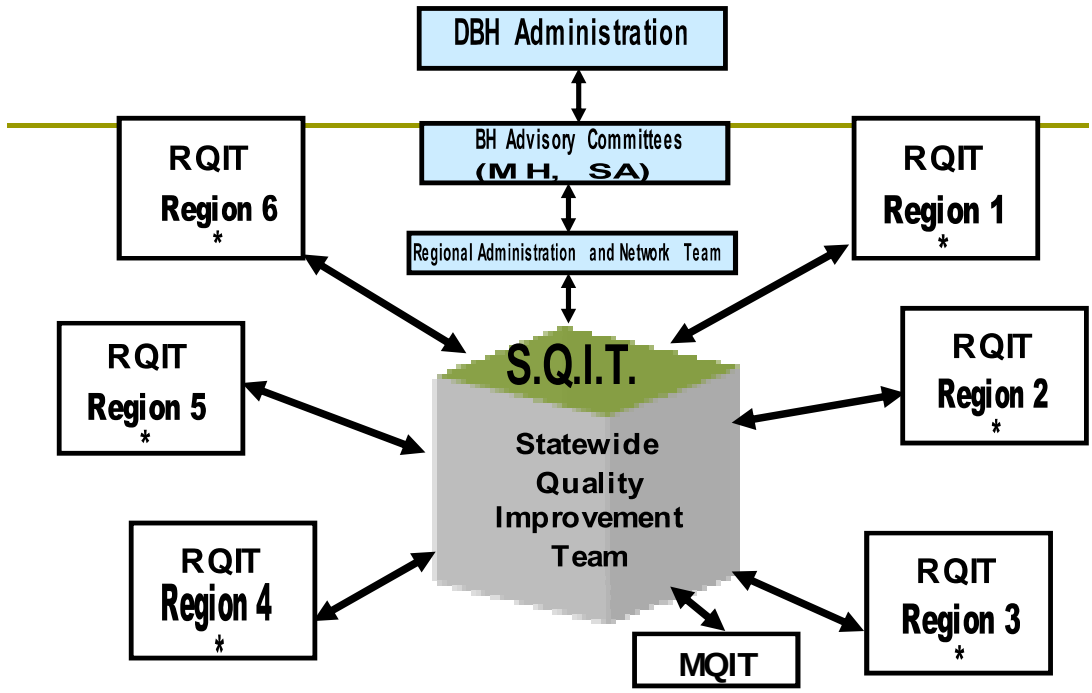


Section 2 **Leadership and Organization**

Leadership and Stakeholders:

Leaders, through a planned and shared communication approach, ensure all stakeholders have knowledge of and participation in ongoing QI activities as a means of continually improving performance. Planned communication methods include posting QI information on the DHHS-DBH public website.

The CQI process must be stakeholder driven. Stakeholders include Consumers and Families, DBH Administration and Staff, Consultants, Regional Staff, Service Providers, Advocacy Groups and Office of Consumer Affairs Participants, Managed Care Staff, DHHS Partners, etc. Working Relationships are pictured and described below.



RQIT = Regional Quality Improvement Team
MQIT = Magellan Quality Improvement Team
*** Each QIT has identified a process for sharing information with stakeholders.**

Division of Behavioral Health Administration **–** The DBH Director and Community Services Section Administrator establish and communicate priorities for the annual plan and review feedback from stakeholders in the reporting structure.
Behavioral Health Advisory Committees (MH, SA) **-** Contributes to the development and implementation of the Annual CQI Plan and activities. The committees meet quarterly.

Membership includes but is not limited to:

- Consumers and Families
- Providers
- Regional Staff
- Justice/Law Enforcement
- DHHS Partners
- Community Stakeholders

The responsibilities include:

- Receiving information from DBH Administration
- Advising DBH and SQIT on the development of the CQI Plan and activities
- Providing input into the creation of quality improvement initiatives
- Assisting in the development of education and communication processes
- Serving as Consultants to DBH representing various viewpoints and concerns
- Reviewing CQI reports and making recommendations
- Assessing Consumer and Family satisfaction survey and other results

Regional Administrator and Network Management Team Meetings **-** Ensure that quality improvement processes are operationalized and prioritized at the community team level. Regional Administrators meet regularly with DBH Administration and the NMT is held quarterly.

Membership includes:

- Regional Administrators
- DBH Team
- Network Team

The responsibilities include:

- Reviewing information from DBH Administration, Advisory Committees
- Providing leadership to the RCQIT
- Assessing recommendations received from RCQIT and SQIT and proposing action
- Reviewing reports, making recommendations for change and ensuring action with RQIT as needed
- Providing technical assistance to the RQIT regarding DBH quality initiatives

Statewide Quality Improvement Team (SQIT) **-** primarily responsible for the identification and prioritization of opportunities for regional/community improvement, quality initiatives and development of the annual plan. 50% of voting membership should have a disclosed lived behavioral health experiences.

Membership includes:
Office of Consumer Affairs Representatives
Regional Staff
Consumer Specialists and other Consumer / Family Members
Providers

Consultants include:
Magellan Staff
DHHS Partners (Medicaid and CFS)
DBH Staff
Regional Center Staff

Voting Membership will include Office of Consumer Affairs Representatives, Consumer Representatives. Regional and provider representation is limited to 2 per region and 1 for the PG provider.

Responsibilities of SQIT in CQI include:

- Revising the Annual QI Program Plan
- Evaluating the effectiveness of the QI Program each year
- Monitoring quality improvement activities of the RQIT
- Recommending system-wide corrective actions for improvement
- Offering recommendations on policies, procedures, service definitions, data quality
- Analyzing results of Consumer, Family and other satisfaction surveys or studies
- Ensuring adequate training exists to support the QI Program
- Ensuring communication of SQIT activities to the agency/organizations/individuals the member represents

Regional Quality Improvement Teams (RQIT) **-** Contributes to the development and implementation of local QI activities as it relates to local needs and the DBH CQI Program Plan. Meetings are held on a regular basis.

Membership includes:

- Consumers
- Regional Staff
- Providers
- Other Community Stakeholders

Responsibilities of RQIT include:

- Bringing community stakeholders together to participate in quality improvement activities
- Developing, implementing and monitoring the community QI Program
- Ensuring data collection and information are used to manage and improve service delivery at the local level
- Providing ongoing information about performance and improvements to persons served
- Supports accreditation processes and compliance with contracts and DBH regulations
- Audits and reviews findings of service providers on an annual basis
- Improves utilization and data management processes through representation on MQIT

Magellan Quality Improvement Team (MQIT) **-** Primary responsibilities include improvement of data quality utilized in QI processes and activities:

- Improving communication and coordination between the Division, Regions, Providers and Magellan
- Developing an understanding of the work flows, systems and processes related to data and making recommendations for improvement
- Establishing a mechanism for the identification, review and resolution of issues
- Reviewing reports and recommending content and format improvements to ensure the presentation of meaningful data
- Meetings are held monthly

Membership of MQIT shall include:

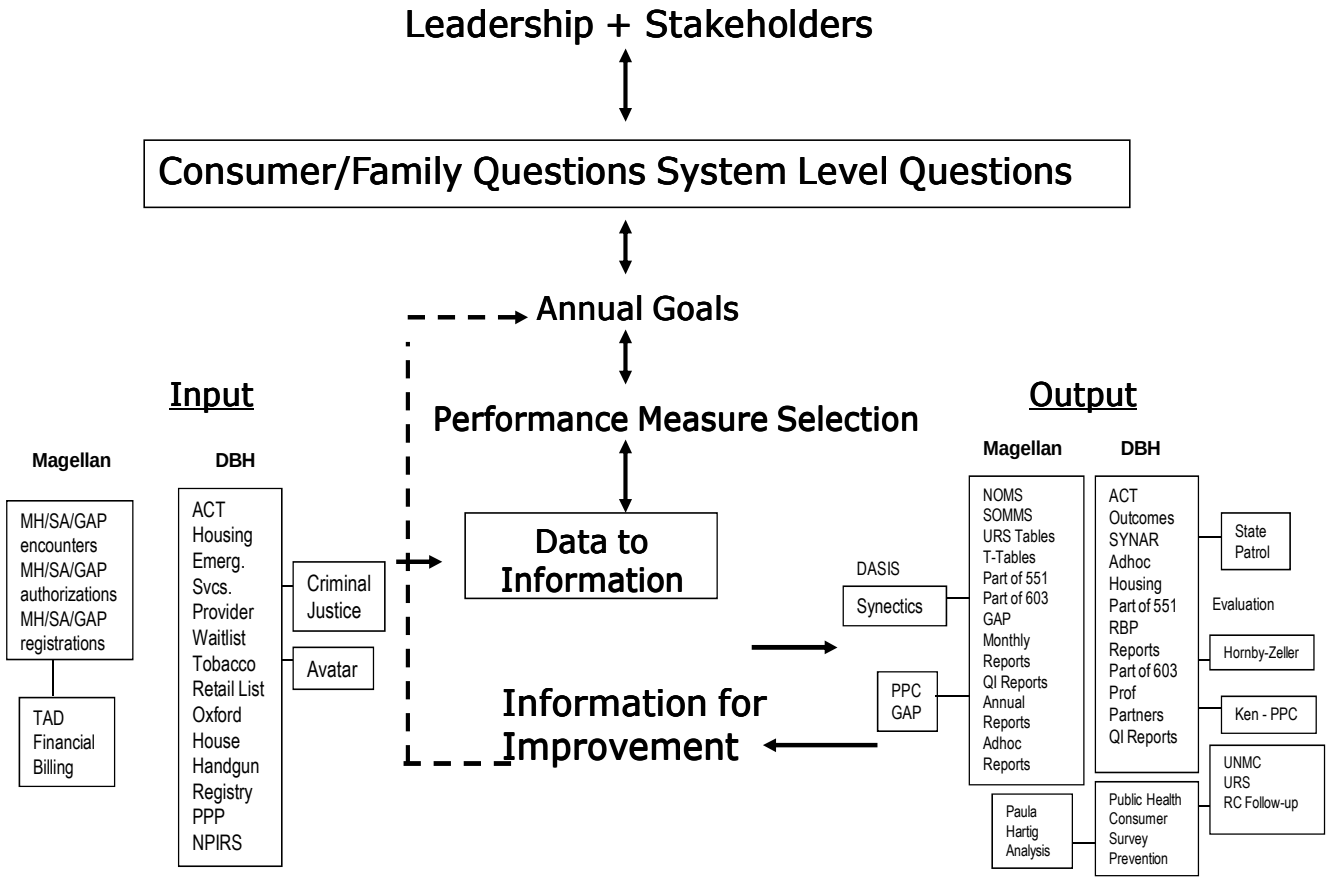
- Regional Representatives
- Hospital Provider
- MH Provider
- SA Provider
- GAP Provider
- Children's Services Provider
- Federation of Families Representative
- DBH – Office of Consumer's Affair Representative
- ASO Staff
- DBH Staff (Team Leader/Facilitator)

QI Program Goals for FY12/13 include:

1. Incorporate the Co-Occurring Quality Initiative Roadmap into the DBH Strategic Plan.
2. Develop and implement performance measurement monitoring and reporting process that is efficient and timely.
3. **Provide education for consumers about quality improvement.**

The following diagram illustrates the process for identifying performance measurements and utilizing data for improvement.

Performance Measurement & Quality Improvement



Section 4 **Performance Measurement**

1. Accessibility Measures
   - NOMS-Perception of Care – Access domain on MHSIP (85%)

2. Quality Measures
   - NOMS-Perception of Care – Outcome domain on MHSIP (80%)
   - 85% of consumers report services received improved their quality of life
   - Increase in total number of providers completing TIC tool
   - Increase in total number of agencies providing trauma specific services

3. Effectiveness Measures

   - NOMS [Employment, stability in housing, criminal/justice, access/capacity, retention]

Section 5 Quality Improvement Initiatives

Quality Initiatives:

A workgroup may be established when:

- A long lasting solution is needed
- The problem is complex and seemingly unsolvable
- The impact of the problem is great
- The problem causes distress and pain for organizations and consumers/families

1. Complete recommendations for FY12 Consumer/Family Survey
2. Co-Occurring Service Delivery Roadmap Integration into the Strategic Plan
3. Evidence Based Practice & Fidelity Monitoring Project [DIG Grant Baseline]
4. **Develop a Quality Improvement Handbook**
5. **Improve the communication processes for the Consumer Survey**

Appendix E:

Substance Abuse and Mental Health Services Administration
National Outcome Measures (NOMs)

DOMAIN	OUTCOME	MEASURES		
		Mental Health	Substance Abuse	
			Treatment	Prevention
Reduced Morbidity	Abstinence from Drug/Alcohol Use	NOT APPLICABLE	Reduction in/no change in frequency of use at date of last service compared to date of first service ▶	30-day substance use (non-use/reduction in use) ▶ Perceived risk/ harm of use ▶ Age of first use ▶ Perception of disapproval/attitude
	Decreased Mental Illness Symptomatology	Under Development	NOT APPLICABLE	NOT APPLICABLE
Employment/ Education	Increased/Retained Employment or Return to/Stay in School	Profile of adult clients by employment status and of children by increased school attendance ▶	Increase in/no change in number of employed or in school at date of last service compared to first service ▶	Perception of workplace policy; ATOD-related suspensions and expulsions; attendance and enrollment
Crime and Criminal Justice	Decreased Criminal Justice Involvement	Profile of client involvement in criminal and juvenile justice systems	Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service ▶	Alcohol-related car crashes and injuries; alcohol and drug-related crime
Stability in Housing	Increased Stability in Housing	Profile of client's change in living situation (including homeless status) ▶	Increase in/no change in number of clients in stable housing situation from date of first service to date of last service ▶	NOT APPLICABLE
Social Connectedness	Increased Social Supports/Social Connectedness[1]	Under Development	Under Development	Family communication around drug use
Access/Capacity	Increased Access to Services (Service Capacity)	Number of persons served by age, gender, race and ethnicity ▶	Unduplicated count of persons served; penetration rate-numbers served compared to those in need ▶	Number of persons served by age, gender, race and ethnicity
Retention	Increased Retention in Treatment - Substance Abuse	NOT APPLICABLE	Length of stay from date of first service to date of last service ▶ Unduplicated count of persons served ▶	Total number of evidence-based programs and strategies; percentage youth seeing, reading, watching, or listening to a prevention message
	Reduced Utilization of Psychiatric Inpatient Beds - Mental Health	Decreased rate of readmission to State psychiatric hospitals within 30 days and 180 days ▶	NOT APPLICABLE	NOT APPLICABLE
Perception of Care	Client Perception of Care[2]	Clients reporting positively about outcomes ▶	Under Development	NOT APPLICABLE
Cost Effectiveness	Cost Effectiveness (Average Cost)[2]	Number of persons receiving evidence-based services/number of evidence-based practices provided by the State	Number of States providing substance abuse treatment services within approved cost per person bands by the type of treatment	Services provided within cost bands
Use of Evidence-Based Practices	Use of Evidence-Based Practices[2]		Under Development	Total number of evidence-based programs and strategies

[1] For ATR, "Social Support of Recovery" is measured by client participation in voluntary recovery or self-help groups, as well as interaction with family and/or friends supportive of recovery.


Department of Health & Human Services
DHHS
NEBRASKA

DHHS-Division of Behavioral Health
Continuous Quality Improvement Program Plan
FY13/14 – WORKING DRAFT

Section 1 Introduction

Vision:
The vision of the Division of Behavioral Health (DBH) and its Quality Improvement Program is to promote wellness, recovery, resilience and self-determination in a coordinated, accessible consumer and family-delivery system.

Mission:
The Division of Behavioral Health leads Nebraska in the improvement of systems of care that promote and facilitate resilience and recovery.

Commitment:
DBH is committed to creating a culture that fosters quality improvement and sets clear direction through an annual plan.

Purpose: **AS A REMINDER**
The DBH Continuous Quality Improvement (CQI) Program establishes accountability for continually improving DBH as an organization and the service provided to consumers and families in the state of Nebraska.

The Division of Behavioral Health CQI program will ensure:

- Services are appropriate to each consumer's needs and accessible when needed;
- Consumers and families participate in all process of the CQI program and their views and perspectives are valued;
- The services provided incorporate best practice, evidence based practice, and effective practices;
- Services are of high quality and provided in a cost-effective manner.

Definition:
CQI is an ongoing process of using data to plan, identifying opportunities for improvement, implementing changes, studying and analyzing results and celebrating improvements.

The CQI Program is based on the following assumptions:
- Working together creates a system of coordinated services to better meet the needs of consumers and families;
- Stakeholders want to improve consumer and family outcomes;
- Stakeholders participate in monitoring activities, data reporting and information sharing.

The DBH's approach to quality improvement is based on the following core principles:

Customers Focused. Understanding and respecting needs and requirements of all customers and striving to exceed expectations.

Strength Based. Effective growth and change build on the consumer/family and system's strengths.

Recovery Oriented. Services are characterized by a commitment to promoting and preserving wellness and choice. This approach promotes maximum flexibility to meet individually defined goals in a consumer's recovery journey.

Representative Participation and Active Involvement. Effective programs involve a diverse representation of stakeholders. The stakeholders are provided the resources, education and opportunity to make improvements required and influence decision making.

Data Informed Practice. Successful QI processes create feedback loops, using data to inform practice and measure results. There is a commitment to seek IT structures, staff, skills and other resources in the provision of data.

Use of Statistical Tools. For continuous improvement of services, tools and methods are needed that foster knowledge and understanding. CQI organizations use a defined set of analytic tools such as run charts, cause and effect diagrams, flowcharts, Pareto charts, histograms, and control charts to turn data into information.

Continuous Quality Improvement Activities. Quality improvement activities emerge from a systematic and organized framework for improvement. This framework, adopted by the Division of Behavioral Health, is understood, accepted and utilized throughout the service delivery system, as a result of continuous education and involvement of stakeholders at all levels in performance improvement.

Plan-Do-Check-Act (PDCA) Model

The recommended model for problem solving and improvement is PDCA. It should be utilized:

- When starting a new improvement project;
- When developing a new or improved design of a process or service;
- When planning data collection and analysis in order to verify and prioritize; and
- When implementing any change.

Plan – Plan for a specific improvement activity

- Recognize opportunity for improvement
- What are the issues?
- Plan a change – who, what, when
- Determine how change will be measured

Do - Do carry out the plan for improvement

- Gain approval and support of the selected improvement solution.
- Implement the improvement solution.
- May use a trial or pilot implementation
- Document observations and data

Check - Check the data again

- Data is analyzed to compare the results of the new process with those of the previous one
- Check for improvement and results
- What was learned?

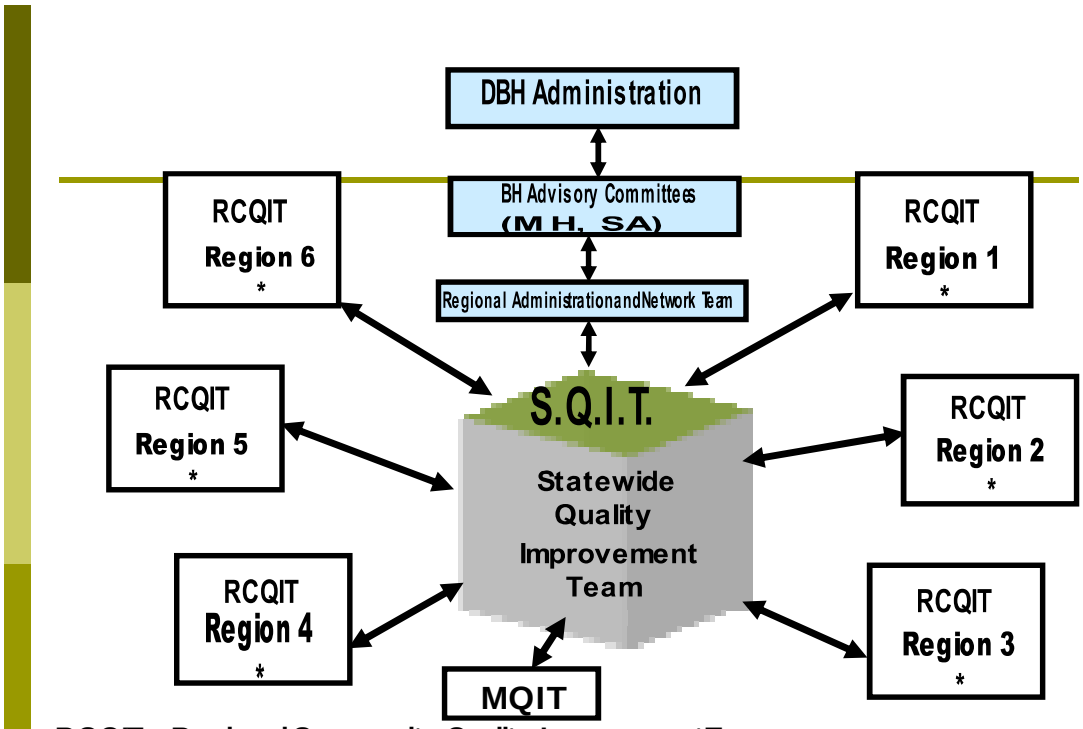
Act – Action for full implementation or reject and try again

- Take action based on what was learned
- Adopt the solution formally as needed, develop policy, etc.
- If there is no improvement refine/revise the solution
- If successful, take action to ensure ongoing improvement

Leadership and Stakeholders:

Leaders, through a planned and shared communication approach, ensure all stakeholders have knowledge of and participation in ongoing QI activities as a means of continually improving performance. Planned communication methods include posting QI information on the DHHS-DBH public website.

The CQI process must be stakeholder driven. Stakeholders include Consumers and Families, DBH Administration and Staff, Consultants, Regional Staff, Service Providers, Advocacy Groups and Office of Consumer Affairs Participants, Managed Care Staff, DHHS Partners, etc. Working Relationships are pictured and described below.



RCQIT = Regional Community Quality Improvement Team
MQIT = Magellan Quality Improvement Team
*** Each QIT has identified a process for sharing information with stakeholders.**

Division of Behavioral Health Administration **–** The DBH Director and Community Services Section Administrator establish and communicate priorities for the annual plan and review feedback from stakeholders in the reporting structure.

Behavioral Health Advisory Committees (MH, SA and PG) **-** Contributes to the development and implementation of the Annual CQI Plan and activities. The committees meet quarterly.

Membership includes but is not limited to:

- Consumers and Families
- Providers
- Regional Staff
- Justice/Law Enforcement
- DHHS Partners
- Community Stakeholders

The responsibilities include:

- Receiving information from DBH Administration
- Advising DBH and S.Q.I.T. on the development of the CQI Plan and activities
- Providing input into the creation of quality improvement initiatives
- Assisting in the development of education and communication processes
- Serving as Consultants to DBH representing various viewpoints and concerns
- Reviewing CQI reports and making recommendations
- Assessing Consumer and Family satisfaction survey and other results

Regional Administrator and Network Management Team Meetings **-** Ensure that quality improvement processes are operationalized and prioritized at the community team level. Regional Administrators meet regularly with DBH Administration and the NMT is held quarterly.

Membership includes:

- Regional Administrators
- DBH Team
- Network Team

The responsibilities include:

- Reviewing information from DBH Administration, Advisory Committees
- Providing leadership to the R.C.Q.I.T.
- Assessing recommendations received from R.C.Q.I.T and S.Q.I.T and proposing action
- Reviewing reports, making recommendations for change and ensuring action with R.C.Q.I.T. as needed
- Providing technical assistance to the R.C.Q.I.T. regarding DBH quality initiatives

Statewide Quality Improvement Team (S.Q.I.T.) **-** primarily responsible for the identification and prioritization of opportunities for regional/community improvement, quality initiatives and development of the annual plan. 50% of voting membership should have a disclosed lived behavioral health experiences.

Membership includes:
Office of Consumer Affairs Representatives
Regional Staff
Consumer Specialists and other Consumer / Family Members
Providers

Consultants include:
Magellan Staff
DHHS Partners (Medicaid and CFS)
DBH Staff
Regional Center Staff

Voting Membership will include Office of Consumer Affairs Representatives, Consumer Representatives. Regional and provider representation is limited to 2 per region.

Responsibilities of SQIT in CQI include:

- Revising the Annual QI Program Plan
- Evaluating the effectiveness of the QI Program each year
- Monitoring quality improvement activities of the R.C.Q.I.T.
- Recommending system-wide corrective actions for improvement
- Offering recommendations on policies, procedures, service definitions, data quality
- Analyzing results of Consumer, Family and other satisfaction surveys or studies
- Ensuring adequate training exists to support the QI Program
- Ensuring communication of S.Q.I.T. activities to the agency/organizations/individuals the member represents

Regional Community Quality Improvement Teams (R.C.Q.I.T.) **-** Contributes to the development and implementation of local QI activities as it relates to local needs and the DBH CQI Program Plan. Meetings are held on a regular basis.

Membership includes:

- Consumers
- Regional Staff
- Providers
- Other Community Stakeholders

Responsibilities of R.C.Q.I.T. include:

- Bringing community stakeholders together to participate in quality improvement activities
- Developing, implementing and monitoring the community QI Program
- Ensuring data collection and information are used to manage and improve service delivery at the local level
- Providing ongoing information about performance and improvements to persons

served
- Supports accreditation processes and compliance with contracts and DBH regulations
- Audits and reviews findings of service providers on an annual basis
- Improves utilization and data management processes through representation on MQIT

Magellan Quality Improvement Team (M.Q.I.T.) **-** Primary responsibilities include improvement of data quality utilized in QI processes and activities:

- Improving communication and coordination between the Division, Regions, Providers and Magellan
- Developing an understanding of the work flows, systems and processes related to data and making recommendations for improvement
- Establishing a mechanism for the identification, review and resolution of issues
- Reviewing reports and recommending content and format improvements to ensure the presentation of meaningful data
- Meetings are held monthly

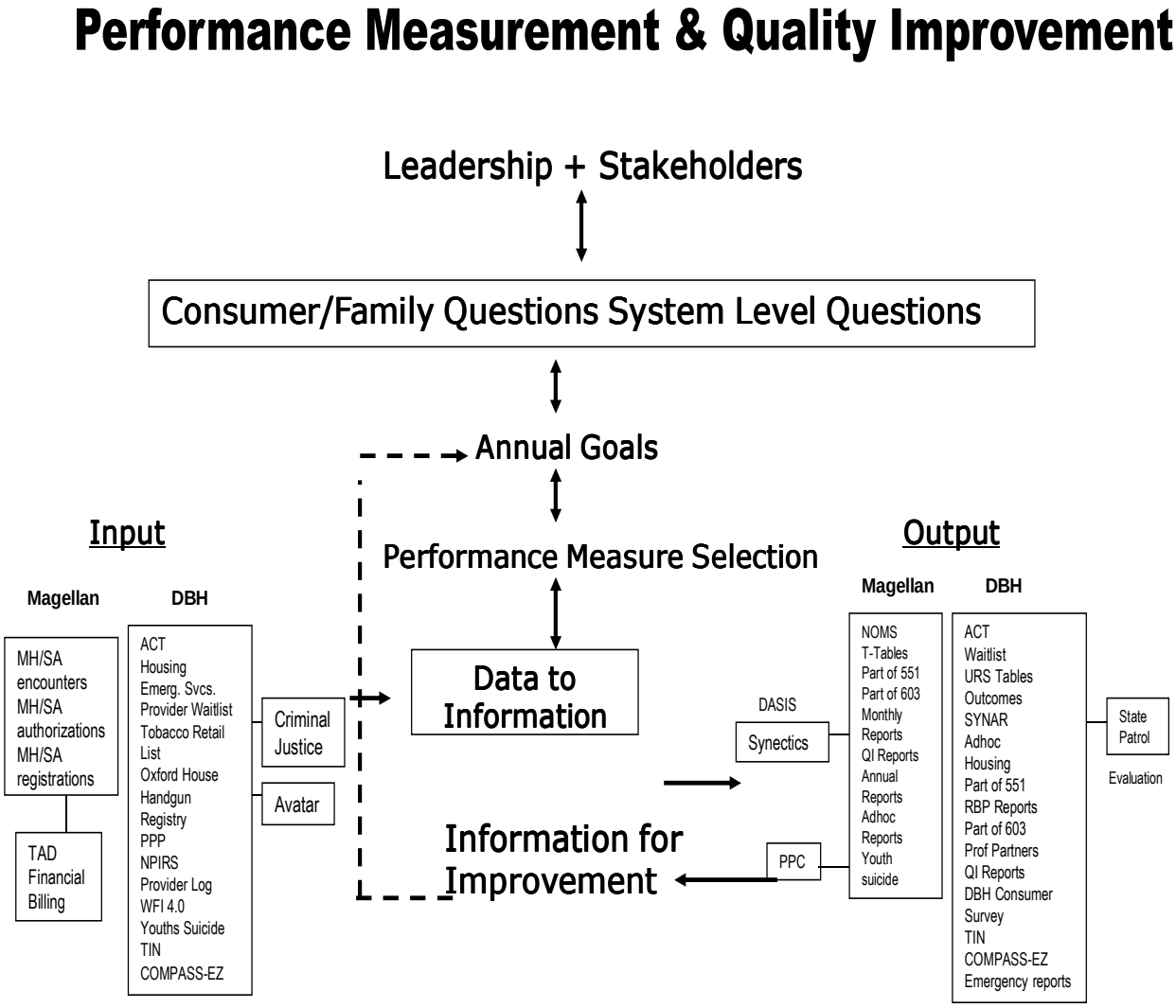
Membership of MQIT shall include:

- Regional Representatives
- Hospital Provider
- MH Provider
- SA Provider
- Children's Services Provider
- Federation of Families Representative
- DBH – Office of Consumer's Affair Representative
- ASO Staff
- DBH Staff (Team Leader/Facilitator)

QI Program Goals for FY13/14 include: **WHAT DO WE NEED NOW?**

4. Begin implementation of the Co-Occurring Quality Initiative Roadmap.
5. Continued implementation of performance measurement monitoring and reporting process that is efficient and timely. Continuous review of necessary data variables required to report on performance outcomes and monitor the data integrity for accuracy.
6. Provide education for consumers about quality improvement.

The following diagram illustrates the process for identifying performance measurements and utilizing data for improvement.



HOW WILL WE KNOW IF WE'VE ACHIEVED OUR GOALS?

4. Accessibility Measures
   - NOMS-Perception of Care – Access domain on MHSIP (85%)

5. Quality Measures
   - NOMS-Perception of Care – Outcome domain on MHSIP (80%)
   - 85% of consumers report services received improved their quality of life
   - Increase in total number of providers completing TIC tool
   - Increase in total number of agencies providing trauma specific services

6. Effectiveness Measures
   - NOMS [Employment, stability in housing, criminal/justice, access/capacity, retention]

Quality Initiatives:

A workgroup may be established when:

- A long lasting solution is needed
- The problem is complex and seemingly unsolvable
- The impact of the problem is great
- The problem causes distress and pain for organizations and consumers/families

6. Co-Occurring Service Delivery Roadmap integration into the Strategic Plan
7. Evidence Based Practice & Fidelity Monitoring Project
8. Develop and implement a Quality Improvement Handbook
9. Improve the communication processes for the Consumer Survey

ARE THESE STILL NECESSARY?